SECTION 6 **PRIOR APPROVAL**

Services Requiring Prior Approval

Prior approval (PA) may be required for some services, products, or procedures to verify medical necessity. All requests for PA must be submitted in accordance with DMA's clinical coverage policies and published procedures (but see discussion about EPSDT non-state plan services in section 6 of this Manual). PA is for medical approval only. PA must be obtained **before** rendering a service, product, or procedure that requires prior approval. Obtaining PA does **not** guarantee payment or ensure recipient eligibility on the date of service. A recipient must be eligible for Medicaid coverage on the date the procedure is performed or the service rendered.

The recipient must meet all medical necessity prior approval criteria. **However**, the federal Social Security Act (the Act) found at 1905(r) requires the state Medicaid agency to provide to Medicaid recipients under 21 years of age "necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." Additionally, if the recipient is under 21 years of age, service limitations on scope, amount, duration, and/or frequency and other specific criteria described in clinical coverage policies may be exceeded or may not apply provided that documentation shows the requested service is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by a licensed clinician. This special provision for recipients under 21 years of age is known as Early and Periodic Screening Diagnostic and Testing (EPSDT). EPSDT criteria are specified below, and all criteria must be met to approve coverage under EPSDT. A list of EPSDT services is located in section 6 of this Manual, page 6-19.

1. The service, product, or procedure must be included in the list of services found in 1905(a) of the Social Security Act.

2. The service, product, or procedure is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination.

3. The service, product, or procedure must be safe and effective.

4. The service, product, or procedure cannot be experimental/investigational.

Please be advised that if a request for a service, product, or procedure requires prior approval, requests made on behalf of recipients under 21 years of age are **NOT** exempt from the prior approval requirement. For further information about EPSDT, refer to section 2 of this Manual, the PA table found in this section, the list of EPSDT services found in this section, and/or DMA's EPSDT Policy Instructions located at the address specified below.

http://www.dhhs.state.nc.us/dma/EPSDTprovider.htm

To determine if a procedure requires PA, please refer to DMA's clinical coverage policies that can be found at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm. Providers may also call the Automated Voice Response (AVR) system at 1-800-723-4337. Refer to **Appendix A** for information on using the AVR system.

Important Points about Prior Approval

1. **In accordance with 10A NCAC 22J.0106(d), providers cannot bill recipients when the provider failed to follow program regulations.**

2. Retroactive PA is considered when a recipient, who does not have Medicaid coverage at the time of the procedure, is later approved for Medicaid with a retroactive eligibility date. exceptions **may apply** as indicated below.

   a. Recipients under the Community Alternatives programs

   b. Hospice Election Reporting PA. Refer to Medicaid's clinical coverage policy **#3D, Hospice Services**, on the DMA website for further information. The web address is http://www.dhhs.state.nc.us/dma/3D.pdf.

   If a recipient has been placed in a nursing facility, the prior approval date for nursing facility level of care may be retroactive to 30 days prior to the date the FL2 is approved by the fiscal agent or up to 90 days with the FL2 and supporting records.

3. Before admitting recipients for procedures requiring PA, hospital office personnel must determine that the physician has completed all of the necessary PA forms. The primary surgeon has the responsibility of obtaining PA from the EDS Prior Approval Unit and/or appropriate DMA staff.

4. Mental health referrals for outpatient services for children may be obtained from the Local Management Entity (LME), Medicaid enrolled psychiatrist, or the primary care physician. This is not an authorization. It is a referral process that must take place **before** the provider sees the child. Authorization must be obtained from ValueOptions.

   For psychiatric services, the admissions are usually emergent, and the hospital has 48 hours to obtain PA from ValueOptions (VO). All other mental health services require prior authorization from ValueOptions as well.

5. Unless a service is exempt from the Carolina ACCESS referral and authorization requirement, providers must obtain a referral authorization from the Carolina ACCESS enrollee's primary care provider in addition to requesting PA for any service or procedure that requires PA. Refer to **Carolina ACCESS Referrals and Authorizations** on page 4-12 for additional information.

6. Some requests for PA are submitted to DMA or DMA's authorizing agents (i.e., CCME, VO, ACS Pharmacy, etc.), but most requests are submitted to Medicaid's fiscal agent, EDS. A few PA requests may be approved verbally by the fiscal agent and followed up with a written request. However, when a request for prior approval may be made verbally to the fiscal agent and it can be approved, the request is approved **tentatively** effective the date of the call contingent upon receipt of the written request within 10 days of the call to the fiscal agent. If the written request is not received in accordance with the required timeframes, the request will be denied. Following the required timeframes, a new PA request may be submitted at any time. Please see the PA table at the end of this section to determine which services may receive **tentative** verbal prior approval.

7. **Except in emergency situations, all services provided to Medicaid recipients by out-of-state providers must be approved prior to rendering the service.**

8. The AVR system provides information regarding a recipient's last routine eye exam or refraction only. It is in the provider's best interest to obtain an authorization/confirmation number on the day of service, prior to rendering the service.

9. DMA staff and vendors will make every effort possible to make a decision about a prior approval request within 15 business days. There may be times when a request for prior approval does not contain sufficient information for Medicaid to determine whether the request should be approved or denied. In that event, Medicaid notifies the recipient and provider in writing that the request lacks the necessary documentation to review the request and specifies the deadline date for submission of additional information by the provider and where/how to submit the information. The provider must submit additional documentation as specified by Medicaid staff or contractors within 15 business days of the date of the notice for additional information.

   Medicaid recognizes that there may be situations when 15 business days are not sufficient time for a response. If a provider is unable to submit the additional information within 15 business days from the date of the request, he/she must contact Medicaid or its contractors to request a time extension. It is not necessary for the provider to explain the reason for the time extension. Medicaid allows the provider no more than an additional 15 business days from the date of the contact to submit the requested information. If there is no response from the provider or if the provider does not submit the additional information within the 15 business

day time period, the provider and recipient are notified in writing that the request was denied for insufficient information.

10. The table that appears at the end of this section summarizes information about some services that require PA. For complete information, refer to individual clinical coverage policies for specific instructions regarding prior approval on DMA's website at the address specified below.

http://www.dhhs.state.nc.us/dma/mp/mpindex.htm

EPSDT General Information

1. For a more detailed explanation of EPSDT, see DMA's EPSDT Policy Instructions at http://www.dhhs.state.nc.us/dma/EPSDTprovider.htm, section 2 of this Manual, and the PA table at the end of this section.

2. EPSDT requirements only apply to recipients **under** 21 years of age.

3. EPSDT does not require the state Medicaid agency to provide any service, product, or procedure that is unsafe, ineffective, or experimental/investigational.

EPSDT and Medicaid Services

1. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. If the recipient under 21 years of age does not meet the coverage criteria set forth in the clinical coverage policy, the provider must request and obtain prior approval from the appropriate authorizing agent **BEFORE** the service is rendered, whether or not prior approval is required.

3. If the service, product, or procedure is **NOT** one for which prior approval is required but the recipient under 21 years of age needs to exceed established limits, the provider must request and obtain prior approval from the appropriate authorizing agent (i.e., EDS, ValueOptions, CCME, DMA, etc.) **BEFORE** the limit is exceeded. Please refer to the prior approval table at the end of this section to determine the appropriate authorizing agent.

4. Prior approval requests for non-covered state Medicaid plan services are requests for services, products, or procedures not included in the North Carolina State Medicaid Plan **but coverable** (medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination) under federal Medicaid law, 1905(r) of the Social Security Act. To review the listing of federal EPSDT services,

products, or procedures coverable under federal Medicaid law, see the listing of EPSDT services in section 6 of this Manual, page 6-19.

5. Requests to cover non-covered state Medicaid plan services must be submitted to DMA prior to rendering the service as described in the PA table at the end of this section beginning on page 6-15.

6. For additional information about EPSDT, please refer to section 2 of this Manual, the prior approval table found at the end of this section, and/or DMA's EPSDT Policy Instructions found at the website specified below.

http://www.dhhs.state.nc.us/dma/EPSDTprovider.htm

EPSDT and Prior Approval

1. EPSDT prior approval authorization is time limited to the first of the following to occur:
   a. recipient reaches 21 years of age **OR**
   b. time limit specified by the prior approval **OR**
   c. 365 days from date of the prior approval.

2. If the recipient is over 21 years of age and the service has not been provided, although prior approval was granted before his/her twenty-first birthday, please follow DMA's published procedures and submit a new request for prior approval, if prior approval is required. See the specific clinical coverage policy and this Manual for complete details re provision of and payment for services rendered. Clinical coverage policies can be found at the website specified below.

http://www.dhhs.state.nc.us/dma/EPSDTprovider.htm

3. If the recipient is under 21 years of age and the authorization has expired and if the service, product, or procedure is still desired and is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by screening, submit a new request for prior approval. See specific clinical coverage policy and this Manual for complete details re provision of and payment for services rendered.

4. The provider has up to 365 days from the date the service is rendered to submit the claim for payment. See specific clinical coverage policy and this Manual for complete details re provision of and payment for services rendered.

5. The service must be rendered in accordance with the PA granted, including service approved, number of units approved, time period of approval, if relevant.

6. If prior approval is required, the provider must request and obtain prior approval **BEFORE** rendering the service, product, or procedure in order to seek Medicaid payment. **REMEMBER**, obtaining prior approval does **not** guarantee payment or ensure recipient eligibility on the date of service. The recipient must meet clinical policy coverage criteria, where applicable, and must be Medicaid eligible on the date the service, product, or procedure is provided.

General Requests for Prior Approval

The Request for Prior Approval North Carolina Medicaid Program form (372-118) is used by several service types to assist in the review of medical necessity for the requested services. PA requests must be submitted in writing using this form. Once a PA has been issued, it must be used within the time limit set forth by the prior approval **OR** within 365 days, whichever time period is less. The services specified below use this form.

- surgery
- out-of-state elective services
- services to Medicaid for Pregnant Women recipients
- hearing aid services
- therapeutic leave over 15 consecutive days
- additional eye exam/refraction services beyond established limitations
- out-of-state and state-to-state ambulance service

  NOTE: A completed and signed State-to-State Ambulance Transportation Addendum form (372-118A) must accompany the PA request.
- transplants (See "Procedures for Approval and Reimbursement of Transplants" in this section).

Where applicable, PA forms should be completed and mailed to Medicaid's fiscal agent:

EDS--Prior Approval Unit
P.O. Box 31188
Raleigh, NC 27622

Requests approved by other authorizing agents must be submitted to that agent. See the PA table at the end of this section to determine the authorizing agent. It is also important to remember that if services are to continue and the PA is time limited, PA must again be requested before the limits are met to avoid an interruption in service provision.

Denial of Prior Approval

A decision on a request for prior approval will be acted on with reasonable promptness (usually within 15 business days of receipt of the request). The provider will be notified in writing of a prior approval, denial, or any reduction or termination of services using the prescribed state form, and the recipient will be notified in writing of any denial, reduction, or termination of services. When a decision is made to deny services or reduce/terminate services for a recipient under 21 years of age, the decision will specify the reasons why the EPSDT standard is not met. The notice will be issued in accordance with DMA's recipient notices procedures. Such a denial can be appealed in the same manner as any Medicaid service denial, reduction or termination. See Section 10 for further detail about denials and appeals.

Requests for Community Alternatives (CAP) Programs

The purpose of the CAP programs is to offer community-based care to certain targeted populations as an alternative to institutionalization as long as the care required can be delivered safely and is cost effective. Admission to and continuation of services in any CAP program requires physician approval and is overseen by a CAP case manager. Admission to the program begins with:

1. a referral to the program;
2. completion of an FL2 signed and dated by the recipient's physician and approved at the nursing facility level of care (for the CAP/AIDS, CAP/C, and CAP/DA programs) or completion of an MR2 and approved at the intermediate level of care for the mentally retarded (ICF-MR) for the CAP-MRDD program;
3. a thorough assessment of the recipient to determine appropriateness for the CAP program; and
4. an evaluation of the assessment and level of care document to determine appropriateness for the CAP program.

NOTE: Case managers are encouraged to submit the FL2 electronically.

The CAP programs, lead agencies, and websites are identified below.

PROGRAM	LEAD AGENCY	WEBSITE
CAP/AIDS	Division of Public Health (DPH)	http://www.ncpublichealth.com
CAP/Children (CAP/C)	DMA–Home Care Initiatives Unit	http://www.dhhs.state.nc.us/dma/mp/mpindex.htm

CAP/Disabled Adults (CAP/DA)	Appointed County Agency For the lead agency listing, please visit http://www.dhhs.state.nc.us/dma/commaltprog.htm	http://www.dhhs.state.nc.us/dma/mp/mpindex.htm
CAP/Mentally Retarded & Developmentally Delayed (CAP/MR-DD)	Division of Mental Health, Developmentally Disabled, and Substance Abuse Services (DMHDDSAS)	http://www.dhhs.state.nc.us/mhddsas/

For further information about the CAP programs, please refer to specific clinical coverage policies, program manuals, and/or websites specified above.

Requests for Prior Approval of Out-of-State or State-to-State Ambulance Service

Prior approval is required for ambulance service by ground or air ambulance from North Carolina to another state, from one state to another, or from another state back to North Carolina. Prior approval for ambulance service is separate from prior approval for a medical procedure or treatment provided out-of-state. Requests for PA must be submitted on the general Request for Prior Approval form (372-118) and the State-to-State Ambulance Transportation Addendum form (372-118A).

Requests for Prior Approval of Long-Term Care Services

The FL2 Long-Term Care Services form (372-124) or FL2e is used by several programs for approval of long-term care nursing services. If a telephone review results in approval of the FL2, the approval is **tentative (not final)**, pending submission of a completed form within 10 days of the telephone call to the fiscal agent. The FL2 must be submitted as the hard copy original or electronically (FL2e) through Provider Link. Should the submitted FL2/FL2e fail to validate that the recipient requires nursing facility level of care at the level specified by the requestor and in accordance with DMA's recipient notices procedure, the request may be denied or reduced, or additional information may be requested. Additionally, if the FL2/FL2e is not submitted within the required timeframe, the FL2/FL2e will be denied. The following services use this form:

- out-of-state long-term care (nursing facility)
- long-term care nursing
- ventilator dependent care
- Community Alternatives Programs (CAP-AIDS, CAP-C, CAP-Choice, CAP-DA) for level of care determinations

Providers are encouraged to submit the FL2 electronically. All electronic requests for long-term care nursing services must be submitted through Provider Link using the FL2e form.

Requests for Prior Approval of Services Provided to the Mentally Retarded

This section is under construction and will be posted at a later date.

Requests for Approval of Optical Services (Routine Eye Exams and Refractions and Visual Aids)

Requests for Routine Eye Exams and Refractions

Routine eye exams and refractions do not require PA. However, it is in the best interest of the provider to obtain approval. If a second eye exam or refraction is requested within the time limitation period, a general Request for Prior Approval form (372-118) documenting medical necessity must be submitted and approved prior to rendering the service.

Refer to Appendix A for information about using the AVR system to obtain PA for eye exams and refractions.

Requests for Prior Approval for Visual Aids

All visual aids require prior approval, and requests must be submitted on a Request for Prior Approval for Visual Aids form (372-017). In some cases, this form must be accompanied by required documentation. Refer to the Optical Services Manual on DMA's website at http://www.dhhs.state.nc.us/dma/optical.htm for information on services and limitations.

Requests for Prior Approval of Hearing Aids, Frequency Modulation (FM) Systems, and Accessories

All hearing aids, FM systems, and accessories require prior approval. Requests must be submitted using the general Request for Prior Approval form (372-118) along with a letter from the physician or otologist stating medical necessity, the results of a hearing evaluation (to include audiogram), and the results of the hearing aid selection/evaluation tests.

- In block 10 on the PA, record the manufacturer, model, and cost of requested aid.
- Also, in block 10, document the type of aid being requested (i.e., ANALOG PROGRAMMABLE, DIGITAL PROGRAMMABLE, OR FM SYSTEM).
- In block 12, document the reason(s) the recipient requires the requested system.

Requests for Prior Approval of Dental Services

Requests for PA for dental services are submitted using the 2002 ADA form. Only PA requests for services that are indicated as requiring PA should be submitted to the EDS Prior Approval Unit. Refer to the Dental Services Policy/Provider Manual (**#4A, Dental Services, #4B,**

Orthodontic Services) on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for information on dental services and limitations.

The two-part form must be used when requesting PA. The original is returned to the provider and serves as the PA/claim copy. The second page is retained by EDS. In order to easily access information submitted for PA, providers are encouraged to make a copy for their office records and note the date the PA was mailed.

Requests for Prior Approval for Durable Medical Equipment and Orthotic and Prosthetic Devices

Some durable medical equipment (DME) items and orthotic and prosthetic devices (O&P) require PA. In those cases, the Certificate of Medical Necessity/Prior Approval (CMN/PA) form must be submitted to EDS for review. The CMN/PA is reviewed to ensure that the item is medically necessary to maintain or improve a recipient's medical, physical or functional level and to ensure that it is suitable and appropriate for use in the recipient's private residence or adult care home.

Requests for Medicaid prior approval DME and orthotics and prosthetics under EPSDT that do not appear on DMA's lists of covered equipment should be submitted to Children's' Special Health Care Services at the address specified below.

POMCS (Purchase of Medical Care Services)*****
NC Division of Public Health
1904 Mail Service Center
Raleigh, NC 27699-1904
Telephone #: 919-855-3701
FAX #: 919-715-3848

PA is valid for the time period approved on the CMN/PA form. If a physician decides that an item is needed for a longer period of time, a new CMN/PA form must be submitted.

Refer to clinical coverage policies **#5A, Durable Medical Equipment, and #5B, Orthotic and Prosthetic Device**s, on DMA's website at http://www.dhhs.state.nc.us.dma/mp/mpindex.htm for additional information.

*****Providers who need general information about the Children's Special Health Services Program and referrals may call the Children with Special Health Care Needs Help Line toll-free at 1-800-737-3028, Monday-Friday, 7:00 a.m.-5:00 p.m. (closed 11 a.m.-1:00 p.m. and state holidays).

Enhanced Care (Adult Care Home Recipients) Approval Process

The adult care home (ACH) staff makes a referral request for enhanced care on behalf of the recipient to the local county department of social services (DSS) by sending a copy of the latest FL2, the 3050R and other referral documents, as necessary. The local DSS assigns a case manager and conducts an independent assessment and approves the recipient for enhanced care services, if appropriate. The case manager calls this approval in to the fiscal agent and receives a service review number. The case manager then sends the resident and the provider a decision notice.

Adult Care Home Special Care Unit for Persons with Alzheimer's and Related Disorders (SCU-A) Approval Process

Effective October 1, 2006, Medicaid will implement a special care rate for Adult Care Home (ACH) providers operating Special Care Units for Persons with Alzheimer's and Related Disorders (SCU-A). The provider must receive prior approval before admitting a new resident to a SCU-A. The provider must complete the Special Care Unit-A Prior Approval Form and submit this along with all supporting documents to Adult Care Homes Unit, NC Division of Medical Assistance, Facility and Community Care Section, 2501 Mail Service Center, Raleigh, NC 27699-2501. A prior approval request form and instructions can be found on DMA's website at

http://www.dhhs.state.nc.us/dma/forms.html.

Hospice Participation

Hospice providers must notify EDS when a Medicaid recipient is admitted to hospice as well as when hospice benefits are revoked, a recipient is discharged from hospice or transfers from one hospice to another. This includes Medicare/Medicaid hospice patients in nursing facilities for whom Medicaid is paying room and board. Hospice participation information may also be obtained using the AVR system for dates of service beginning May 01, 2000.

Refer to **Appendix A** for information about using the AVR system.

Utilization Review for Psychiatric Services

The Medicaid program contracts with ValueOptions to provide utilization review of acute inpatient/substance abuse hospital care for recipients, Psychiatric Residential Treatment Facilities (PRTF), Levels I through IV Residential Treatment Facilities, therapeutic foster care outpatient psychiatric services, enhanced benefits, and Criterion #5. ValueOptions reviews and approves the requests based on medical necessity according to established criteria.

For recipients **over 21 years of age** and after the eighth visit, providers must obtain authorization from ValueOptions for continued outpatient mental health services. Recipients **under 21 years of age** are allowed 26 unmanaged visits before prior approval is required. If services are to continue for recipients **under 21 years of age**, prior approval is required beginning with visit 27.

Copies of the PA form can be obtained by calling ValueOptions at 1-888-510-1150.

Refer to the **Enhanced Benefit Mental Health/Substance Abuse Services, May 2006 Special Bulletin** on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm for additional information.

Prior Approval for Outpatient Specialized Therapies

The Medicaid program contracts with the Carolinas Center for Medical Excellence (CCME) to perform the PA process for outpatient specialized therapies. PA is required for continued treatment after six unmanaged visits, per discipline, per provider type.

If treatment is to continue after the six unmanaged visits, the PA request should be made at approximately the second or third unmanaged visit to allow sufficient time for processing. A completed and signed **Prior Authorization Request for Outpatient Specialized Therapy Services Form** and supporting documents must be faxed to CCME at 1-800-228-1437 for treatment to be continued. If appropriate, CCME will authorize services for a specific number of units through a specific length of time. Units should be requested based on the CPT code billed. A copy of the form is available on CCME's website at http://www.thecarolinascenter.org/.

Once the limits have been reached, PA must again be requested for continued treatment.

Refer to **Clinical Coverage Policy #10A, Outpatient Specialized Therapies**, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for additional information.

Prior Approval for Certain Prescription Drugs

The Medicaid program contracts with ACS State Healthcare to manage the PA process for the drugs specified in the listing below. From time to time, additional drugs requiring PA may be added. Providers will be notified of such additions and changes via DMA's general Medicaid Bulletin found on DMA's website at http://www.dhhs.state.nc.us/dma/bulletin.htm and/or DMA's Pharmacy Newsletter found at http://www.dhhs.state.nc.us/dma/pharmnews.htm.

- Procrit, Epogen, Aranesp
- OxyContin
- Provigil
- Botox, Myobloc
- Neupogen
- Growth hormones
- Celebrex
- Sedatives/hypnotics

The prescriber contacts the ACS Clinical Call Center (in Henderson, North Carolina) directly by telephone, fax, e-mail or mail. Should a pharmacy need to dispense medication to a recipient in an emergency, the pharmacist can dispense a 72-hour supply without PA.

Copies of the prescription PA forms may be obtained by calling ACS State Healthcare at 1-866-246-8505 or online at http://www.ncmedicaidpbm.com.

Procedures for Approval and Reimbursement of Transplants

When a hospital transplant team determines that a recipient requires a transplant (solid organ or stem cell), all of the supporting documentation justifying the medical necessity for the procedure must be sent to DMA for pre-approval **if Medicaid will be the primary payer**.

Retroactive PA will not be authorized for any recipient who does not have Medicaid coverage at the time of the procedure except when a recipient is later approved for Medicaid with a retroactive eligibility date.

Upon review of the documentation, the physician and the facility will receive a notification of approval or denial from DMA. DMA does not authorize transplants for enrollees who have Medicare or private insurance. In order for DMA to review a request for transplant coverage for a dually eligible recipient, providers must submit a copy of the Medicare denial/payment with the request for coverage of the transplant and the complete transplant evaluation packet.

Packets are to be faxed to the transplant nurse consultant at 1-919-715-0051. The packet must include the documentation specified below as well as the clinical documentation indicated in the specific transplant policies and available on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm.

Solid Organ Transplant Packets:

- Letter from physician requesting transplant and summarizing clinical history
- All recent lab results inclusive of HIV, RPR, Hepatitis panel, PT, INR, infectious disease serology inclusive of CMV, and EBV

***See below for complete lab requirements. No lab results can be more than three months old.**

- All recent diagnostic and procedure results (**not** more than three months old)
- Complete psych/social evaluation with documentation of post transplant care needs of patient and/or family, as indicated, that accurately depict support, compliance etc.
- Psychiatric history will require a psychiatric evaluation.
- History of or active substance abuse requires documentation of substance abuse program completion and six months of negative sequential random drug and alcohol screens.

NOTE: To satisfy the requirement for sequential testing as designated by policy, DMA must receive a series of test (alcohol and drug) results spanning a minimum six-month period, allowing no fewer than a three-week interval and no more than a six-week interval

between each test during the given time period. A complete clinical packet for prior approval must include at least one documented test performed within one month of the date of request to be considered.

• Other organ specific policy criteria (Refer to the web address specified below).

http://www.dhhs.state.nc.us/dma/mp/mpindex.htm

•Additional clinical and or documentation may be requested.

Stem Cell Packets:

• Letter from physician requesting transplant and summarizing clinical history

• Previous chemotherapy regimes and dates

• All recent lab results inclusive of HIV, RPR, Hepatitis panel, PT, INR, infectious disease serology inclusive of CMV, EBV

***See below for complete lab requirements. No lab results can be more than three months old.**

• All diagnostic and procedure results inclusive of bone marrow aspiration (**not** more than three months old)

• Complete psych/social evaluation with documentation of post transplant care needs of patient and/or family, as indicated, that accurately depict support, compliance etc.

• Psychiatric history will require a psychiatric evaluation.

• History of or active substance abuse requires documentation of substance abuse program completion and six months of negative sequential random drug and alcohol screens as specified above.

• Other disease specific policy criteria (Refer to the web address specified below).

http://www.dhhs.state.nc.us/dma/mp/mpindex.htm

• Additional clinical and or documentation may be requested.

***Lab results** required in a complete packet include:
CBC, liver enzymes, complete electrolytes, PT, INR, HIV, Hep, RPR, EBV, CMV, Varicella, rubella, T protein, Ca, BUN, HSV I/II amylase, lipase, phosp, mag, AFP (depending on the diagnosis), glucose and AIC, cholesterol and trig (depending on history), blood type, MELD/PELD score, LD, uric acid, T. bili, GGT, recipient height and weight

Other lab tests may be requested.

PRIOR APPROVAL TABLE FOR CERTAIN MEDICAID SERVICES

Service	Verbal Authorization	Written Authorization
Community Alternatives Program (CAP/AIDS, CAP/C, CAP/Choice, CAP/DA) **This approval is for level of care only and does not constitute approval to participate in any of the CAP programs.**	Call the fiscal agent, EDS, at 1-800-688-6696 or 1-919-851-8888 to receive **tentative** verbal approval. Information "called in" to the fiscal agent must be from a completed N.C. Medicaid Program Long-Term Care Services form (FL2) (372-124).	After receiving **tentative** verbal approval, the completed N.C. Medicaid Program Long-Term Care Services form (FL2) (372-124) must be received by EDS within 10 days of the telephone call (hard copy original FL2 or electronic FL2e through Provider Link). See "Requests for Prior Approval of Long-Term Care Services" in this section for further information. Case managers are encouraged to use the FL2e whenever possible.
Dental	No verbal authorization allowed.	Complete a 2002 ADA claim form and submit to EDS .
Durable Medical Equipment	Call EDS at 1-800-688-6696 or 1-919-851-8888 to receive verbal approval for emergency repairs to orthotic or prosthetic **only**.	Complete a Certificate of Medical Necessity and Prior Approval form 372-131 (8/02) and submit to EDS.
EPSDT: For State Medicaid Plan Services for Recipients **Under 21 Years of Age**	No verbal authorization allowed.	If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval. If the recipient under 21 years of age does not meet the coverage criteria set forth in the clinical coverage policy, the provider must request and obtain prior approval from the appropriate authorizing agent **BEFORE** the service is rendered, whether or not PA is required.

Service	Verbal Authorization	Written Authorization
		If the service is **NOT** one for which prior approval is required but the recipient under 21 years of age needs to exceed clinical coverage policy limits, the provider must request and obtain prior approval from the appropriate authorizing agent (i.e., EDS, ValueOptions, CCME, DMA, etc.) **BEFORE** the limit is exceeded. Submit completed applicable program PA form(s) to the **appropriate authorizing agent** along with documentation that shows the request will correct or ameliorate a defect, physical or mental illness, or a condition identified by a licensed clinician **before** providing the service. If additional information is required, the reviewer will request it.
EPSDT: Non-covered State Medicaid Plan Services for Recipients **Under 21 Years of Age** Requests for non-covered state Medicaid plan services are requests for services, products, or procedures not included in the North Carolina State	No verbal authorization allowed. **IMPORTANT NOTE:** **THIS PROCEDURE IS ONLY FOR REQUESTING SERVICES UNDER EPSDT THAT ARE NEVER COVERED UNDER THE N.C. MEDICAID STATE PLAN. TO REQUEST COVERED SERVICES FOR RECIPIENTS UNDER 21 YEARS OF AGE IN EXCESS OF NUMERICAL LIMITS OR OTHER SPECIFIC CRITERIA IN CLINICAL COVERAGE POLICIES, SEE EPSDT FOR STATE MEDICAID PLAN SERVICES IMMEDIATELY ABOVE.**	PA must be requested and obtained **prior** to rendering any non-covered state Medicaid plan service. Only those services included in the list of services found in 1905(a) of the Social Security Act can be approved and reimbursed by N.C. Medicaid. Submit completed Non-Covered State Medicaid Plan Services Request form **before** providing the service, product, or procedure to: EPSDT Request Assistant Director Clinical Policy and Programs Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501

Service	Verbal Authorization	Written Authorization
Medicaid Plan **but coverable** under federal Medicaid law, 1905(r) of the Social Security Act. To review the listing of EPSDT services, products, or procedures coverable under federal Medicaid law, please refer to the listing on page 6-19 of this section or to DMA's EPSDT Policy Instructions found at the website specified below. http://www.dhhs.state.nc.us/dma/EPSDTprovider.htm		Form may be found at the end of this section or on DMA's website at the address specified below. http://www.dhhs.state.nc.us/dma/forms.html Recipients may also obtain a request form by calling the **CARE-LINE Information and Referral Services**, Monday-Friday, except state holidays, at the numbers specified below. **The form must be completed by the recipient's physician or other licensed clinician.** • Outside Triangle Area:1-800-6 • Outside Triangle Area:1-877-4 • Inside Triangle Area:919-855-4 Inside Triangle Area: 919-733-4851 (TTY number for the deaf or hearing impaired) The reviewer will determine if the requested service, product, or procedure is included in the list of coverable services found in 1905(a) of the Social Security Act. Additionally, documentation must show that the request will correct or ameliorate a defect, physical or mental illness, or a condition identified by a licensed clinician. The requested service must also be safe, effective, and it cannot be experimental/investigational. If additional information is required, the reviewer will request it.
Eye Examinations and Refractions	Call the AVR system at 1-800-723-4337 to receive verbal approval (or 1-800-688-6696 if the AVR system is not in service).	Complete a general Request for Prior Approval form (372-118) for medically necessary exceptions to the time period limitations and

Service	Verbal Authorization	Written Authorization
		submit to EDS.
Hearing Aids and Accessories	No verbal authorization option is available.	Complete a general Request for Prior Approval form (372-118) and submit to EDS.
Hospice	Call EDS at 1-800-688-6696 or 1-919-851-8888 to report hospice benefit election.	Hospice election must be reported within 7 calendar days of the start of hospice services. Prior approval for hospice reporting cannot be granted retroactively beyond the 7 day timeframe.
Intermediate Care/Mental Retardation Services	Section under construction and will be posted at a later date.	Section under construction and will be posted at a later date.
Long-Term Care (FL2)	Call EDS at 1-800-688-6696 or 1-919-851-8888 to receive **tentative** verbal approval pending receipt of the FL2 or FL2e as specified above and in this table.	After receiving **tentative** verbal approval, the completed N.C. Medicaid Program Long-Term Care Services form (FL2) (372-124) must be received by EDS within 10 days of the telephone call (hard copy original FL2 or electronic FL2e through Provider Link). See "Requests for Prior Approval of Long-Term Care Services" in this section for further information. Providers are encouraged to use FL2e.
MPW Recipients	No verbal authorization option is available.	Complete a general Request for Prior Approval form (372-118) and/or complete appropriate referral form for service requested.
Out-of-State Non-Emergency Services	Call EDS at 1-800-688-6696 or 1-919-851-8888 to receive information and instructions for obtaining out-of-state approval. No authorizations can be granted verbally.	Complete a general Request for Prior Approval form (372-118). A letter from the attending physician requesting out-of-state services, indicating why the services cannot be provided in North Carolina and medical records must accompany the prior approval form. The requests should be faxed to 1-919-233-6834.
Outpatient Specialized Therapies	No verbal authorization option is available.	Fax a Prior Approval for Outpatient Specialized Therapies form and supporting documents to the

Service	Verbal Authorization	Written Authorization
		Carolinas Center for Medical Excellence at 1-800-228-1437.
PCS-Plus	No verbal authorization option is available.	Complete a PCS-Plus Request Form (DMA 3000-A) and fax the form to DMA at 1-919-715-2628. The form is available online at the address specified below. http://www.dhhs.state.nc.us/dma/forms.html#prov
Prescription Drugs	Call ACS State Healthcare at 1-866-246-8505 for information and instruction re PA for prescription drugs.	Fax completed Pharmacy PA forms to ACS State Healthcare at 1-866-246-8507.
Private Duty Nursing	Upon review of faxed information, the PDN consultant will provide verbal authorization as indicated. The provider may call DMA at 1-919-855-4380 for PDN consultation.	Complete and fax a PDN Referral form and a Physician's Request form which documents medical necessity to DMA at 1-919-715-9025. Forms are located as specified below. http://www.dhhs.state.nc.us/dma/forms.html#prov.
Psychiatric Services, Inpatient (PRTF, Residential Child Care, Criterion #5, Out-of-State and Residential Services)	Call ValueOptions at 1-888-510-1150.	
Psychiatric Services, Outpatient, Enhanced Benefit Services, Developmental Disability, and CAP-MRDD	Call ValueOptions at 1-888-510-1150.	
Out-of-State and State-to-State	Call EDS at 1-800-688-6696 or 1-919-851-8888 to receive information and instructions for obtaining out-of-state	Complete a general Request for Prior Approval form (372-118). A completed and signed Out-of-State

Service	Verbal Authorization	Written Authorization
Ambulance Service	and state-to-state ambulance services approval. No authorization can be granted verbally.	and State-to-State Ambulance Transportation Addendum form (372-118A) must accompany the prior approval form. EDS will notify the provider when and how to submit the request.
Surgery	Call EDS at 1-800-723-4337 to verify if a surgery requires prior approval. No verbal authorization option is available.	Complete a general Request for Prior Approval form (372-118) and submit to EDS. Include documentation supporting medical necessity along with photographs, if required. Refer to individual clinical coverage policies to determine information required for a specific surgery at the address stated below. http://www.dhhs.state.nc.us/dma/mp/mpindex.htm
Therapeutic Leave (limited to 15 days per quarter for children in residential services)	Not applicable	Authorization is embedded in the residential authorization as therapeutic leave is a part of the plan of care and must be documented as such.
Tocolytic Infusion Therapy	No verbal authorization option is available.	Complete a Tocolytic Prior Approval Request Form and fax to the Carolinas Center for Medical Excellence (CCME) at (919) 380-9457. Applicable supporting documents should be included. Forms can be obtained from DMA website, http://www.dhhs.state.nc.us/dma/forms.html#prov.
Transplants	No verbal authorization option is available.	Completed packets/requests are to be faxed to the DMA transplant nurse consultant at 1-919-715-0051. See "Procedures for Approval and Reimbursement of Transplants" in this section for further information and packet/request requirements.
Visual Aids	No verbal authorization option is available.	Complete Prior Approval Request for Visual Aids form (372-017) and

Service	Verbal Authorization	Written Authorization
		submit to EDS. Include documentation of medical necessity for exceptions.

LISTING OF EPSDT SERVICES FOUND IN THE SOCIAL SECURITY ACT AT 1905(a)

- Inpatient hospital services (other than services in an institution for mental disease)
- Outpatient hospital services
- Rural health clinic services (including home visits for homebound individuals)
- Federally-qualified health center services
- Other laboratory and X-ray services (in an office or similar facility)
- EPSDT *(Note: EPSDT* offers periodic screening services for recipients under age *21 and Medicaid covered services* necessary to correct or ameliorate a *diagnosed physical* or mental condition)
- Family planning services and supplies
- Physician services (in office, patient's home, hospital, nursing facility, or elsewhere)
- Medical and surgical services furnished by a dentist
- Home health care services, including nursing services, home health aides, medical supplies and equipment, physical therapy, occupation therapy, speech pathology, audiology services
- Private duty nursing services (in the recipient's private residence)
- Clinic services (including services outside of clinic for eligible homeless individuals)
- Dental services
- Physical therapy and related services (includes occupational therapy and services for individuals with speech, hearing, and language disorders)
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Other diagnostic, screening, preventive, and rehabilitative services, including medical or remedial services recommended for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level (in facility, home, or other setting)
- Services in an intermediate care facility for the mentally retarded
- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle
- Hospice care
- Case management services
- TB-related services
- Respiratory care services
- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Primary care case management services

- Any other medical care, and any other type of remedial care recognized under state law, specified by the secretary (includes transportation)

North Carolina

Department of Health and Human Services

Division of Medical Assistance

2501 Mail Service Center - Raleigh, N.C. 27699-2501

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

L. Allen Dobson, Jr., M.D., Assistant Secretary
for Health Policy and Medical Assistance

NON-COVERED STATE MEDICAID PLAN SERVICES REQUEST FORM

RECIPIENT INFORMATION: ***Must be completed by physician, licensed clinician, or provider.***

NAME:_____

DATE OF BIRTH:____/____/_____*(mm/dd/yyyy)* **MEDICAID NUMBER:**_____

ADDRESS: _____

_____

MEDICAL NECESSITY: ***ALL REQUESTED INFORMATION, including CPT and HCPCS codes as well as provider information must be completed. Please submit medical records that support medical necessity.***

REQUESTOR NAME:_____**PROVIDER NAME:**_____
MEDICAID PROVIDER #:_____**MEDICAID PROVIDER #:**_____

ADDRESS:_____**ADDRESS:**_____

_____ _____

TELEPHONE #: (___)_____**TELEPHONE #: (___)**_____

FAX #:_____**FAX #:**_____

IN WHAT CAPACITY HAVE YOU TREATED THE RECIPIENT ***(incl. length of time you have cared for recipient and nature of the care)*****:**_____

_____

_____

PAST HEALTH HISTORY ***(incl. chronic illness)*****:**_____

_____

_____

NAME OF REQUESTED PROCEDURE, PRODUCT, OR SERVICE. (*MUST incl. applicable CPT AND HCPCS codes).* PROVIDE DESCRIPTION RE HOW REQUEST WILL CORRECT OR AMELIORATE THE

RECIPIENT'S DEFECT, PHYSICAL AND MENTAL ILLNESS OR CONDITION. _____

_____

_____

1 of 2 -OVER-

NAME: **MID #:** **DOB:**

RECIPIENT DIAGNOSIS(ES) RELATED TO THIS REQUEST *(incl. onset, course of the disease, and recipient's current status)*:_____

_____

TREATMENT RELATED TO DIAGNOSIS(ES) ABOVE *(incl. previous and current treatment regimens, duration, treatment goals, and recipient response to treatment(s)*:_____

_____

_____

_____

IS THIS REQUEST FOR EXPERIMENTAL/INVESTIGATIONAL TREATMENT:

___YES ___NO IF YES, PROVIDE NAME AND PROTOCOL #_____

_____

IS THE REQUESTED PRODUCT, SERVICE, OR PROCEDURE CONSIDERED TO BE SAFE:
___YES ___NO IF NO, PLEASE EXPLAIN._____

_____

IS THE REQUESTED PRODUCT, SERVICE OR PROCEDURE EFFECTIVE:

___YES ___NO IF NO, PLEASE EXPLAIN._____

_____

ARE THERE ALTERNATIVE TREATMENTS THAT COULD BE TRIED: ___YES ___NO IF NO, SPECIFY WHY ALTERNATIVES ARE INAPPROPRIATE AND SUBMIT EVIDENCE BASE WITH THIS REQUEST.

WHAT IS THE EXPECTED DURATION OF TREATMENT:_____

WHAT ARE THE EXPECTED TREATMENT OUTCOMES RELATED TO THIS REQUEST:

ADDITIONAL INFORMATION MUST BE SUBMITTED ON PROVIDER'S LETTERHEAD AND SIGNED BY THE PHYSICIAN OR LICENSED CLINICIAN MAKING REQUEST.

REQUESTOR'S SIGNATURE AND CREDENTIALS **DATE**

MAIL OR FAX COMPLETED FORM TO:

Assistant Director

Clinical Policy and Programs

Division of Medical Assistance

2501 Mail Service Center

Raleigh, NC 27699-2501

FAX: 919-715-7679